PATIENT DEMOGRAPHICS- WORKER'S COMPENSATION OR ATTORNEY PATIENT

Patient Name:

Last Name: _____ First Name: _____ Middle Initial: _____

Parent/Guardian If applicable: _____

Date of Birth: _____/_____/_____ SS# _____-_____-_____ E-Mail: _____

Phone: (H) _____-_____-_____ (C) _____-_____-_____ (W) _____-_____-_____

May we communicate to you by: E-mail? _____ Yes _____ No **or** Texting? _____ Yes _____ No

Marital Status: Single _____ Married _____ Other _____ Full Time Student: _____ Yes _____ No

Sex: **M F O** (***Please Circle One)***

Address:

House Number: _____ Street: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Attorney Information: Motor Vehicle Accident?: **YES NO** *(Please circle one)*

Attorney Name: _____ Date of Injury: _____-_____-_____

Address: _____

State: _____ Zip Code: _____ Phone: _____-_____-_____

E-Mail: _____ @ _____. _____

Workers-Comp Information:

Employer: _____ Occupation: _____

Workers-Comp Company: _____ Date of Injury: _____-_____-_____

Claims Address: _____

State: _____ Zip Code: _____ Phone: _____-_____-_____

Claim Number: _____

Adjuster's/Case Manager Name: _____ Phone: _____-_____-_____

CONSENT: I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and I have had the opportunity to ask questions regarding the information on this form. When the technologist takes you back for your exam please make sure and lock up your belongings in the locker you are assigned to at the time of your procedure DFW MRI is not responsible for any personal belongings! DFW MRI has a complaint resolution process if you are not satisfied please notify the staff at any time.

Signature: _____ Date: _____-_____-_____

HIPAA AND MEDICAL RECORDS RELEASE

I hereby authorize DFW Open MRI, LP to use and/or disclose my protected health information as described below to: **(FAMILY MEMBERS, TREATING DOCTORS, and ATTORNEYS)**

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

For the following purposes: **(describe each purpose of use/disclosure - If disclosing different types of information below for different purposes, the authorization must specify the purpose for which each type of information is being disclosed.)**

_____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying DFW Open MRI, LP in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) DFW Open MRI, LP agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, my case attorney, or my case manager; federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of Information to Be Disclosed

- ☐ Entire Medical Record
- ☐ Office Chart Notes
- ☐ Billing Statements
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Consultation
- ☐ Discharge Summary
- ☐ Emergency Room Reports
- ☐ Most Recent 5 Year History
- ☐ All Hospital Records
- ☐ Transcribed Hospital Reports
- ☐ History and Physical Exam
- ☐ Emergency and Urgent Care Records
- ☐ Medical Records for Continuity of Care
- ☐ Diagnostic Imaging Reports
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other _____

_____

_____

Expiration:
This authorization will expire 7 years from the date of signing.

Patient Name: _____ **Patient ID #:** _____

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

_____ _____
Signature of Witness **Date**

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND AUTHORIZATION TO: DFW MRI, L.P. AND RADIOLOGIST

I hereby direct any and all insurance carriers, attorneys, agencies, government departments, companies, individuals, and/or other legal entities ('payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illness, past or future ("condition"), to pay directly to, and exclusively in the name of DFW MRI, L.P. such sums as may be owing to DFW MRI, L.P. for charges incurred by me, including but not limited to charges for treatment, narrative reports, depositions, testimony and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to DFW MRI, L.P. with respect to my charges, applicable to all payers; however, I understand that nothing in this Agreement shall be constructed as an election by DFW MRI, L.P. to claim protection under any statutory lien law. For the purpose of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, if a payer refuses to pay DFW MRI, L.P. I hereby assign to the Office, insofar as permitted by law, the following: all of my rights, remedies, and benefits to DFW MRI, L.P. as well as any and all causes of action that I might have against such payer to the extent of my charges, the right to prosecute such causes of action either in my name or in the office name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. In the event that I retain one or more attorneys to represent me in this matter, I hereby direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this Office regarding any funds received by the attorney relating to my accident, to promptly pay the Office out of such funds, and to the Office upon its request I hereby direct all payers to release to

DFW MRI, L.P. any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize this office to release any information regarding my treatment which pertains to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize DFW MRI, L.P. to endorse / sign my name on any and all checks listing me as a payee which are presented to this Office for payment of an account relating to me, my spouse, or any of my dependents. I further authorize DFW MRI, L.P. to apply any credit balance on charges incurred by me to any other outstanding charges still owed by me, my spouse, or dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amount due DFW MRI, L.P. for their services. This Agreement does not constitute any consideration for this Office to await payment and it may demand payment from me immediately upon rendering services at its option. If this Office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse DFW MRI L.P. for all costs of such collection efforts, including but not limited to, all court costs and all attorney fees.

This Agreement shall not be modified or revoked without the mutual written consent of DFW MRI, L.P. and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the term, of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonable and necessary for the protection of the rights and interest of DFW MRI, L.P. and me. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Signature of Person Completing Form: _____ Date: _____-_____-_____
Relationship to Patient: Self Spouse Guardian *(Please Circle One)*

NOTICE OF PRIVACY PRACTICE

All patients are able to obtain a copy of DFW MRI's notice of privacy practices. I understand that I am able to access that information and I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Person Completing Form: _____ Date: _____-_____-_____
Relationship to Patient: Self Spouse Guardian *(Please Circle One)*

For office use only:

We attempted to obtain written acknowledgement of receipt or our notice of privacy practices on the following date but acknowledgement could not be obtained because:

0 Patient or representative refused to sign 0 Emergency situation prevented us from obtaining acknowledgement at this time

0 Communication barriers prohibited obtaining acknowledgement